Testimony of Charles E. Hallberg
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Before the House Energy and Commerce Health Subcommittee
May 23, 2006

Good morning Chairman Deal and members of the Committee. I am happy to be here today to testify on the partnership with pharmacists to implement Medicare Part D.

I am the founder and President of MemberHealth, the sponsor of the Community Care Rx program, the fourth-largest stand-alone Part D plans in the country with about one million enrollees. I founded MemberHealth in 1998 as a pharmacy benefit management company, and we operate prescription insurance and discount programs through our national network of over sixty thousand network pharmacies. Prior to the start of Part D, we supported a successful Medicare Drug Discount Card, with 450,000 enrollees.

As we approached the MMA, we thought this was a tremendous opportunity to re-align the business of providing prescription drugs to ensure that beneficiaries, pharmacies, physicians, plans, and the government all faced consistent incentives. To help us achieve this goal, we collaborated with the National Community Pharmacists' Association (NCPA) to build a program that leverages the pharmacists' skills to provide the best clinical outcomes and most financial value for the Medicare beneficiary.

In designing the CCRx program, we focused on the idea that meeting the beneficiary's needs is paramount – if we do that everything else will work itself out.

We believe it is in the beneficiary's best interest to have the most appropriate care at least cost, so we've implemented a program with the help of our pharmacists to ensure that our enrollees take advantage of the savings available to them from generic drugs. Our generic incentive program provides higher dispensing rates to pharmacies that meet generic dispensing rate goals. This payment increase, provides an incentive for pharmacists to spend extra time helping our enrollees save money and has proven very effective. The CCRx generic dispensing rate is about sixty percent, well above industry averages and we believe well above Part D plan averages. In addition to saving money for our enrollees, this high generic dispensing rate will save Medicare money because as we control costs better, Medicare will save through lowered bids and reduced risk corridor costs.

We believe it is in the beneficiary's best interest to have a strong relationship with their pharmacist, so we designed our Medication Therapy Management (MTM) program to support this relationship. While other Part D plans have chosen to implement MTM programs via remote methods – phone calls or other avenues – our MTM program pays pharmacists to work directly with our enrollees. Once our system identifies enrollees who meet the MTM requirements, we send the information to the enrollee's pharmacy to schedule an MTM session, where the pharmacist reviews the enrollee's drugs to look for any clinical problems or savings opportunities. We believe that this close interaction will help our enrollees better manage their diseases and their costs by tapping into our pharmacists' expertise.

We believe it is in the beneficiary's best interest to have an opportunity to review their drug use and ways to comply with our formulary with a pharmacist as part of their transition to CCRx. We are now implementing a process to pay our pharmacists to perform this review for all new enrollees to CCRx starting next month. We developed this initiative because one of the lessons we learned in the first months of Part D is the importance of ensuring as smooth a transition as possible for new enrollees, and we're enlisting our pharmacists to look for clinical red flags in our new enrollees' drug use as well as opportunities to move to formulary drugs or generics or to begin formulary exception processes early if need be.

While our focus will always be on serving the beneficiary, we recognize that our network pharmacies are businesses and we work hard to ensure that we're the best business partner we can be. As noted above, we've provided incentives for generic dispensing so that we pay for performance, and we pay our pharmacists to perform MTM and transition reviews, recognizing that the pharmacists need to make a commitment to providing these services and must be compensated appropriately.

We also make timely payment to our pharmacies a priority. We pay our pharmacies twice per month – on the 1st and 15th of each month. These payments correspond to two claims cycles per month. Two cycles per month is the industry standard for the commercial marketplace. Weekly payments are the standard for many State Medicaid programs. The first cycle covers claims incurred from the 1st through the 15th of the month, while the second cycle covers the 16th through the end of the month. Payments

for each claims cycle are issued 15 days following the end of a cycle. As an example, claims incurred from March 1st through March 15th are paid to the pharmacies on April 1st. We have also issued a payment calendar so that our pharmacies can monitor their payments for the remainder of 2006.

To further improve the timeliness of our payments, we recently began processing electronic fund transfers (EFTs), for those pharmacies electing that option for the claims cycle ending March 31st. We currently pay electronically for about 35% of our claims, and we are working to have the majority, if not all, of pharmacies on our EFT program, because this will cut at least five days off of the payment cycle and allow for better controls to ensure that the pharmacies are paid the right amount at the right time.

Before I close, I would be remiss if I didn't mention the outstanding efforts of our network pharmacies in dealing with the Part D program's start up troubles. I hope my testimony demonstrates that we at MemberHealth have sought consistently to support our pharmacies in delivering the best care to our enrollees, but the pharmacists in the community went above and beyond the call of duty and we will be eternally grateful for those efforts.

In closing, let me reiterate my thanks for the invitation to address the Committee and say that we believe our focus on meeting the beneficiaries' prescription drug needs through strong patient-pharmacists relationships will provide tremendous value to the beneficiaries, the pharmacies, and the Medicare program for years to come.